

Bonhoeffer's explanation of a lesion in the extension of the anterior cerebellar peduncle into the subcortical ganglia as the most probable theory concerning posthemiplegic chorea. In every one of his 160 cases there was some muscular atrophy, more marked as the paralysis was marked, affecting the upper more than the lower limb and, in the majority of cases, accompanied with sensory symptoms. In the large number considerable atrophy was also observed on the so-called sound side. Arthropathies, as described by Marie, occur in most cases of hemiplegia. They affect mostly the shoulder joint, but with marked contractures other joints also may be involved. Weisenburg thinks the cause is probably the forced immobility plus the pulling on the articulations and tendons by the weight of the paralyzed member. Lesions of cells of the anterior horns are not common in hemiplegia and, in the cases examined, no pathologic changes were found here. He notes, however, one or two peculiar cases, and in two or three of his patients there were painless arthritic conditions suggesting somewhat the arthropathies of chronic spinal disease. This paper is to be followed by a pathologic study of hemiplegia.

LOCOMOTOR ATAXIA. J. W. Rhein (Journal A. M. A., Feb. 25, 1905).

In this the author reports a case of locomotor ataxia with a typical clinical history, save that there appeared with or soon following the appearance of the tabetic symptoms a fine rhythmical tremor in both hands and arms. This was quieted by voluntary motion, but afterward increased. No other symptom suggesting paralysis agitans was present, and the pathologic findings at the autopsy were those characteristic of well-developed tabes. The case is of interest on account of this occurrence of tremor, which is not usually observed as a symptom of tabes. The author suggests that it may possibly be a case of this disease associated with paralysis agitans. The arterial conditions were not such as are usually associated with senile tremor.

A CASE OF LANDRY'S PARALYSIS. C. H. Foley (British Medical Journal, Jan. 7, 1905).

An agriculturist, aged 35 years, of temperate habits, first noticed that his feet felt benumbed and weak. A few days later his lower limbs were completely paralyzed, the paralysis rapidly extending to his hands, arms and trunk. Sensation was dulled, but there was no anesthesia. The paralysis was flaccid and the tendon and superficial reflexes were lost. Deglutition was noisy and spasmodic, and constipation was absolute for some days. There was tenderness over the mid-dorsal spine and in the muscles of the limbs on deep pressure. Treatment consisted of the administration of a saline diaphoretic, containing 20 minims of ferric chloride to each dose, every four hours. The spine was blistered along its whole length and later massage was given twice daily. He recovered gradually and was completely well in two months, although the knee-jerks remained diminished to some extent.

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THE PAINS OF TABES. Sir Wm. R. Gowers (British Medical Journal, Jan. 7, 1905).

In a clinical lecture on this subject, the author discusses in detail the symptom of pain occurring in tabes dorsalis. He divides the pains according to their character, into two classes. In Class A are those in which the pains are very brief and succeed each other, after intervals, in the same place. These pains are further divided into superficial and deep. The superficial pains are commonly referred to as "lightning pains," and leave the skin area involved sore to touch. The second variety of the brief pains is deep seated, but not referred to any

definite structure. Class B includes those that are prolonged, sometimes hours or more, of varying intensity and with remissions, but not intermissions. They are more commonly truncal, but may affect any part of the body, and their diagnosis from local organic disease is very important. A subdivision of the second class consists of widely diffused sensations, such as cold, heat, swelling, etc., seldom amounting to real pain, but distressing on account of their persistence. Under the heading, "Tabetic Neuralgia," the author summarizes the symptoms of eleven cases which form in his experience a special variety of tabes, in that the pains are the only prominent symptom and the knee jerks are not lost. He assumes that there is a difference in the casual agent, the toxin, in these cases, as there is when the toxin has a special tendency to act on the optic nerves. All these cases were in adult men with a history of syphilis in 9 of the 11, and an average interval between the primary disease and the onset of pain of 12 years. The knee jerks were normal in degree and equal on the two sides in 8 out of the 11 cases. In two cases they were unequal, but in only one was there a lost reflex, and then only on one side, the other side remaining normal. In two cases the light reaction of the pupils was lost, in two others it was slight, but present, and in two it was completely lost only on one side. One case presented characteristic optic nerve atrophy. Sensation was quite normal in most cases. The pains presented many of the variations met with in ordinary tabes, and were generally severe. The inference that the extremities of the peripheral nerves is the source of the tabetic pain agrees best with the known facts concerning them, though other portions of the nervous system may play a part in their production. For the relief of the pain the coal tar derivatives are of most value when the pains are of moderate intensity. They are most effectual when given in one large dose at the onset of the attack. In later and more severe cases morphine must be used. The tendency to the attacks may be relieved by the chloride of aluminium, in doses of 5 to 10 grains, three times a day, and a similar influence may sometimes be obtained with the salicylate series of drugs.

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MUSCLE ATROPHY WITH TABES J. Hagelstam (Finska Läkarsällskh, 45, p. 635).

The author reports the case of a man without bad heredity; possible lues and alcoholic history. At the age of 16-18, having lifted heavy weights, strained himself, and was also much exposed to cold weather. From the time when he was 18 years old he noted a marked grade of weakness of the arms. Later a similar weakness of the legs and thighs developed. At the age of 20 many of his teeth dropped out, and at the same time he had attacks of diplopia. These were helped by the use of glasses. In late years, inability to hold the bladder contents, weakness of the anal sphincter and shooting pains in the legs. Examination showed marked muscular atrophy of the muscles of the shoulder, the right upper arm and thigh. The forearm and hand showed no atrophy. The legs were thinned, in extreme hypertension, marked hypotonus, Patellar reflex lost, Achilles and abdominal reflexes active; no ataxia in reclining position. No Romberg, papilla pale gray; acuteness of vision and visual fields not modified; diminished sensibility of the toes and also some change in position perception. The case is interpreted as one of mild involvement of the combined posterior columns with progressive muscular atrophy.

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